MEDICAL SOCIETIES.

CALIFORNIA ACADEMY OF MEDICINE.

Meeting held January 20, 1906, the president, Dr. P. K. Brown, being in the chair.

Atheroma of the Aorta. Dr. Wm. Ophüls demonstrated specimens of atheromatous aorta which had been injected at blood pressure with paraffine. Contrary to Thoma's contention, these show no bulging of the muscle beneath the atheromatous plaques. Since they were taken from an early stage in the disease, they show very clearly that the thickening of the intima is not caused by any primary weakening of the muscularis. The newer histological methods favor the view that arterio-sclerosis is an inflammatory condition.

Genu Recurvatum. Dr. H. M. Sherman showed a boy, 15 years old, who suffered from an extreme genu recurvatum. As an infant he had had a spinal kyphosis that had been cured by a plaster jacket. A little later he developed a tuberculosis of the left knee joint. At 8 years an erasion of the joint was done and two later operations were performed on the knee, in one of which the external popliteal nerve was cut. The deformity of the knee is extreme and is increasing and the boy suffers pain after walking a few blocks. Dr. Sherman stated that in his own experience an erasion of the knee joint is practically always followed by a tendency to flexion, which latter takes place even though the joint be in splints. This flexion proceeds to about 35° and then stops. It is much less likely to take place if the continuity of the extensor tissues over the front of the joint be preserved. The patient here exhibited reverses the ordinary rule and shows extension instead of flexion.

Dr. Rixford stated that the radiograph shows that the line of the lower end of the femur is obliquely placed, the posterior edge of the femur projecting downward farther than the anterior. We cannot tell whether this resulted from an extensive operative excavation of the anterior part of the femur, from an absorption of the anterior part of the bone, or from an excessive growth of the posterior portion. The after treatment of the case may have been such that the knee tended to sag as it would if the leg had been supported by the heel. Similar deformities occur not infrequently when fractures of the leg are treated by Plaster of Paris splints.

Hydrocyanic Acid Poisoning. Dr. T. C. McCleave reported a series of cases of hydrocyanic acid poisoning that had resulted from the attempt to exterminate the roaches in a lodging house. The poisonous fumes diffused to distant parts of the house, especially through an open clothes chute. The patient most severely affected stated that after noticing the odor of the gas, she felt nauseated and dizzy and then vomited profusely. After a brief period of fullness and whirling in the head, she became unconscious. When discovered shortly after, she was extremely cyanotic, the mucous membranes were injected, and the muscles rigid. Urine was voided involuntarily. She remained unconscious for about eight hours. She was given artificial respiration, oxygen, and the usual cardiac and respiratory stimulants. Epinephrin, in the form of adrenalin chlorid solution, 45 minims, seemed to determine the recovery more than did anything else. Headache, nausea, and vomiting persisted for some days. The cyanosis also lasted for some days and seemed to be dependent on changes in the blood itself. In addition to this patient, all who had assisted in removing her from the room were more or less affected, being prostrated with headache, vertigo, nausea, and vomiting. The blood examination of one of these showed 4,000,000 red cells; 9,000 leukocytes; and a normal differential count. The urine was scant and smoky but showed no albumin.

Dr. Rixford spoke of the value of epinephrin in surgical shock. He has seen the blood pressure rise markedly after injections of this substance, and in one case in which strychnine and salt solution had been previously administered, he felt confident that the epinephrin solution had saved the patient's life.

Dr. Ophüls stated that the action of epinephrin solutions in large doses seems to be very uncertain when injected into rabbits. On one day a rabbit will tolerate a certain dose very well; whereas on the next day it will succumb in a few minutes to the same dose from the same bottle.

Thyroid Operations. Dr. W. I. Terry reported a series of nine operations on the thyroid gland with no deaths. Eight of these patients had more or less severe symptoms of exophthalmic goitre and all were improved as a result of the operation. In several, the X-ray and the serum treatments had been previously tried without success. In all the right lobe was much larger than the left. The operation was essentially that elaborated by Kocher. A local 1% cocaine or eucaine anesthesia was employed and the speaker felt confident that the pain during the latter parts of the operation were not to be measured with the dangers of a general anesthetic. In one patient while tying the inferior thyroid artery, the voice suddenly became squeaky and it only needed a readjustment of the ligature to free the nerve which was not itself seen. The collar incision was preferred both because it gives a better exposure of the gland and because it leaves a better cosmetic result. The individual vessels were isolated and tied. As a rule the stump of the gland was cauterized with carbolic acid and a small drain was left in for 24 hours.

Paroxysmal Tachycardia Associated with Exophthalmic Goitre. Dr. P. K. Brown reported in detail one of the cases that had been operated upon by Dr. Terry. A woman, 41 years old, gave a history of paroxysmal tachycardia since she was 12 years old. One of her children also has these attacks. She was observed in several paroxysms of tachycardia, during which her pulse rate reached 280 per minute. Gradually a small goitre developed associated with tremor, general nervousness, pigmentation of the skin, and marked general weakness. Over a period of two years, she was treated with various medical remedies, including two kinds of dried serum from thyroidectomized animals and the X-ray, but without any other effect than could be accounted for by the rest in bed. After a part of the gland was removed she improved immediately and considerably.

Dr. Cheney stated that he had treated six cases of exophthalmic goitre with thyroidectine and that in four the results have been very satisfactory. The nervousness, tachycardia, exophthalmos, and tremor have all disappeared. The goitres however have remained. In one of these cases the remedy has now been suspended for three months and no symptoms have recurred. Many cases of exophthalmic goitre seem to run a self-limited course and if the symptoms can be relieved the disease will terminate of itself. Others must come to the surgeon but the operation should be a last resort and should not be performed until medical treatment has been given a fair trial.

Dr. S. Stillman stated that he has now under his charge for other conditions two patients who had previously suffered from exophthalmic goitre with enlargement of the thyroid, rapid pulse, and tremor. They had both recovered spontaneously. He is not in favor of early operations on comparatively mild cases.

Dr. E. Rixford advocated the use of thyroidectine as a preliminary to operation. By its use the danger of the operation may be materially reduced; especially when the tachycardia improves and the heart recovers its tone.

Dr. Dudley Tait stated that he had recently visited Jaboulay's clinic in Lyon and had seen some of the results that follow sympathectomy. The exophthalmos and enlargement of the thyroid are nearly always improved. Patients with marked nervous symptoms and those with pronounced tachycardia are not considered favorable subjects for this operation. The operation is comparatively free from danger. The difficulty with local anesthesia in this country is that the people do not realize the dangers of general anesthesia and are not tolerant to pain. For this reason many operators find it necessary to use ether in goitre operations.

A. W. HEWLETT.

SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE AND THROAT SURGEONS.

Regular meeting January 18, 1906, Dr. George Merritt in the chair.

"The Adjusting of Eye-Glasses and Spectacles," Dr. George Brady.

Dr. Brady called attention to the necessity of the oculist understanding the underlying principles of this subject. Usually the optician has this part of the prescribing of glasses entirely in his hands. All of us get cases where it is advisable to give the optician exact instructions in regard to the necessary changes and, for this reason, a working knowledge of the subject is indispensable. The doctor explained the technical procedure of fitting, having numerous frames to make the work practical.

Dr. Pischel said that he considered this the work of the optician and sends his patient back as often as he finds that the glasses are not properly adjusted. In this way the optician is made to realize the importance of his work, and thus becomes educated to the fact that a little care in the beginning will save him extra work.

Dr. Eaton mentioned that often there exists assymmetry of the face, with the result that one eye is nearer to the nose than the other. This point is frequently overlooked by the optician.

Dr. Brady, in closing, said that he has noticed this assymmetry of the face repeatedly; in fact, it is the rule, and not one face out of twenty is really symmetrical.

Dr. Eaton described a case of injury to the eye. The patient came, complaining of pain in an eye which had been injured with a piece of glass six years before. The glass had cut the cornea and sclera over the ciliary body, and had evidently penetrated into that region. The bulbus was tender to the touch and atrophied. Enucleation was recommended. A piece of glass was found in the orbital fat, and it was necessary to go behind Tenon's Capsule. After 48 hours the stump was movable in the usual way but, instead of being cup-shaped, was rather convex or pushed out. The next morning he was informed that the patient had convulsions, epileptoid in character, during the night, and extreme pain in the stump. This latter was now collapsed and a thin serum-like substance exuded. He had no further symptoms, the orbit healing promptly.

Dr. Nagel wished to know whether the man had ever had similar fits.

Dr. Franklin said that a temporary pressure extending to the brain cavity could explain the condition.

Dr. Eaton, in closing, explained that as he went behind the capsule slight sepsis might have been present with increase of the arachnoid fluid, thus causing the convulsions by pressure. The symptoms subsided as soon as the stump drained.

Dr. K. Pischel showed the following case: Patient, a miner, was injured about one year ago by the explosion of a blast in a quartz mine. He was treated in Denver; the inflammation passed off and the patient returned to his work. Examination showed scar in the center of the cornea of the right eye, iris adherent to same. Hanging to the iris is a small piece of quartz, ½ mm. in diameter. Pupil covered partially with a secondary cataract, substance of lens absorbed, with clear space remaining in the upper portion. In the cataract fine sand. Disc shows some whitish scars, and below a tear in the choroid. X-Ray picture was taken in Denver and three opacities were seen. The question is: "Are we to attempt operative removal of the foreign bodies and failing enucleate the eye or leave the eye alone"?

Dr. Eaton would leave the eye alone if the man was sufficiently intelligent to return upon the first sign of irritation.

Dr. Nagel agreed with Dr. Eaton, and would leave the eye alone as long as there was no secondary glaucoma, shrinkage or other signs of active irritation.

Dr. Franklin thought that as the foreign bodies were attached to the iris it would not be difficult to remove them, and all that was necessary was removal of that portion of the iris containing the foreign bodies. The man being a miner and, through his occupation, living in remote places we should not subject him to the possibility of sympathetic ophthalmia without the proximity of a competent oculist.

Dr. Pischel, in closing, said that he thought the eye could stand these foreign bodies very easily and he would not suggest removing same. The man sees the movement of the hand readily and can distinguish fingers outwards and downwards.

Meeting of February 3, 1906.

The president, Dr. George Merritt, in the chair.

Dr. Fredrick reported "An Unusual Case of Mydriasis," saying that the patient, a man, presented himself with complete dilatation of the right pupil which had come on suddenly over night. The left was partially dilated. He was at a loss to know the cause; he had put nothing into the eyes, and nobody in the house had eye trouble. He had had a similar attack once before. Patient had asthma and was using a patent medicine for same. Such remedies often contain soda and belladonna. The circular read that when taking this medicine one must abstain from all alcoholics and patient remembered that he had taken a glass of wine after the remedy. The mydriasis was overcome with eserine. "We should all be on the lookout for similar cases of so-called 'Idiopathic Dilatation,' which in fact are due to some remedy which passes by unsuspected."

Dr. Martin reported two cases in which the mydriasis was caused by the use of suppositories for hemorrhoids.

Dr. Merritt remembered having seen bilateral dilatation after the use of belladonna-plasters applied to the back.

Drs. Brady and Pischel reported similar cases of bilateral dilatation due to the internal use of belladonna in some form or other.

Dr. Fredrick reported, "Darier's Results with Radium," saying in closing: "There are, at present, a large number of men experimenting in this direction but as radium is so expensive it is practically impossible for the individual to have some of it. I suggest that the society buy a small amount out of its funds and in this way open the field for further investigation."

Dr. Pischel showed the new chisels of Miles, of New York. They are particularly useful in sinus work, entering easily forward and cutting out a piece when pulled backwards. They are extremely useful within the sphenoidal sinus as the chisel enters easily and an assistant, by hammering, gets out a piece of the anterior wall. In operating on the antrum Dr. Pischel shoves back the mucous membrane, makes a small opening and then with the chisels, just described, enlarges same saving the membrane as much as practical. He has seen a case where the face was edematous the next day after the use of these chisels.

Dr. Welty considered these chisels too sharp for the sphenoidal cavity and not suitable, as the wall is often as thin as paper and one is working close to the brain in a cavity already infected. He does not consider the opening of the antrum through the nose as sufficient but does the radical operation.

Dr. Philip thought that Miles' instruments were well adapted for this class of work and particularly in removing the anterior wall of the sphenoidal cavity. As these instruments cut principally backward and do not go upward he did not see how any of the important structures could be endangered.

Dr. Martin said that all instruments are dangerous in unskilled hands but that these instruments, though perfectly safe, would not help us much so far as the sphenoidal sinus was concerned. He thought the edge too round to cut into the hard bone at the base of the sphenoid.

Dr. Pischel, in closing the discussion, said that the question of danger in regard to these instruments had been answered by Dr. Philip. One works only downward and outward with them. He does not consider them as sufficiently strong for the thick bone at the lower part of the sinus. Dr. Miles does not pull them out but has his assistant use the hammer backwards, in this way avoiding tearing the walls.

"A Persistent Case of Episcleritis," Dr. Geo. H. Powers. The patient, a woman about 30 years of age, came with the right eye showing marked episcleritis. She was well otherwise and examination showed no constitutional disease. Dr. Powers treated the patient on the assumption of rheumatism, giving large daily doses of the salicylates. After lasting seven months the eye cleared and patient has not had a return of the trouble. The case was peculiar inasmuch as there was no evidence of rheumatism, although treatment established that it was the cause of the condition.

Dr. Martin said that he had used dionin with good results, but cases of episcleritis are exceptionally obstinate to treat and some of them last seven or eight months in spite of the most approved treatment.

Dr. Barkan did not consider this an excessive length of time for such a malady and cited a case of his which resisted all local treatment and was cured only when sent to one of the Hot Springs with the resultant constitutional regime.

Dr. Nagel emphasized the necessity of keeping the possible luetic origin of this trouble before us. He had a case which resisted the usual salts and although lues was not marked the inunctions of mercury were immediately beneficial.

Dr. Eaton, mentioned that he had found two efficient remedies for this condition, one being colcichin, recommended by Darier, the other citarin. This latter remedy he uses in the most persistent cases and has seen it clear up an obstinate one in 48 hours.

Dr. Powers, closing the discussion, mentioned that he had forgotten to say that he had tried dionin without result and the case was presented as it differed, to his mind, from the ordinary episcleritis, which, at best, is a sluggish disease.

W. SCOTT FRANKLIN, Secretary.

THE PROPRIETARY MEDICINE FROM THE PHARMACIST'S STANDPOINT.

"In the eyes of the professional pharmacist, the physician prescribing any of these preparations is either an ignoramus or a charlatan, or both, mostly both. The pharmacist is compelled by law to be thoroughly familiar with the drugs he dispenses, and to examine them for purity, etc. The 'caveat emptor' of ordinary commerce is changed into 'caveat vendor' in the case of pharmacy. With chemicals, even of those protected by patent, which are really scientific discoveries, he can easily assume responsibility. Chemical tests are at his command. But what can he do with preparations which never had a chemical test, and never could have a chemical test, because they are mechanical mixtures, and because the manufacturers can and do change their composition at will. The M.D. who prescribes these preparations is on a par with the customer who buys Lydia Pinkham's, or Father John's, with this difference: that the layman who takes the statements of the manufacturer for truth pays for it himself, while the doctor makes the patient pay for it, and often gets a little rake-off from the manufacturer in the shape of discount.

Let us now view the effect which the prescribing of such remedies has on the three classes most affected.

First comes the physician. After the detail man or the manufacturer's ad. has insulted the M.D.'s intelligence by telling him what to prescribe, the manufacturer proceeds to separate the doctor from his patients in a most ingenious manner. He tells the M.D. that to insure the genuineness of the preparation he must write for an original bottle. Right here he undermines his friend, the M.D., for before very long the article has been so well introduced by the aid of the guileless M.D. that the people buy it over the counter without paying the M.D. his fee for recommending it. This is the financial phase for the M.D.

There is also another phase. When the M.D. has become accustomed to let the detail man think for him, he has given up medicine thinking altogether. His first impulse after diagnosing a case is to call for some proprietary remedy, irrespective of what its actual constituents may be, without regard to idiosyncrasies in the patient and without the possibility of knowing what secondary effects that particular dope may produce. Often he is puzzled by what he supposes to be newly developed symptoms, which are nothing less than after effects from some of the constituents of the (to him) unknown remedy. The effect on the patient is a matter not to be lightly passed over. We pharmacists often have occasion to judge it.

I will relate an incident which happened not long ago in my store. A lady brought in a prescription asking for a proprietary tablet whose chemical test consists of the monogram on top. After receiving the medicine she opened the box, and on discovering that the tablets were old friends of hers, which she had been buying in 25-cent boxes over the counter, she said some very uncomplimentary things about the M.D., and wound up by declaring that hereafter she would consult a doctor who wrote 'real medicine.' The evil of self-medication is largely due and directly attributed to the prescribing of proprietary preparations by the M.D.

To compel the druggist to dispense preparations of this ilk, is to rob him financially and to insult him professionally. He is compelled to stock up on 40 to 50 acetanilid preparations, the numberless bromide mixtures, the legion of dope cure-alls, and simply because the physician is too indolent or too ignorant to compose his own prescriptions.

That there are a number of valuable preparations of proprietary origin, nobody will deny. That the M.D. has a right to use them in his daily practice is equally true, but it is up to the physician to differentiate between an ethical proprietary and a fake with a high-sounding name, and when in doubt there is always at the command of the practicing physician that great and, alas, often neglected, book, the United State Pharmacopeia."—P. J. Diner in *Am. Druggist.*

After removal of the appendix symptoms of appendicitis sometimes persist, leading the patient to believe that the organ had not been extirpated. These are generally due to a colitis, which must be treated by high irrigations, diet, etc.—*International Journal of Surgery.*